1 2 3 4 5 6 7 8	EDMUND G. BROWN JR. Attorney General of California ALFREDO TERRAZAS Senior Assistant Attorney General GLORIA A. BARRIOS Supervising Deputy Attorney General State Bar No. 94811 300 So. Spring Street, Suite 1702 Los Angeles, CA 90013 Telephone: (213) 897-2540 Facsimile: (213) 897-2804 Attorneys for Complainant BEFORE THE BOARD OF REGISTERED NURSING DEPARTMENT OF CONSUMER AFFAIRS STATE OF CALIFORNIA
10	
11	In the Matter of the Accusation Against: Case No. 2010 - 416
12	KIMBERLY LYNN WALKER 232 S. Lomita Street A C C U S A T I O N
13	Burbank, CA 91506 Registered Nurse License No. 654439
.14	Respondent.
15	ixespondent.
16	Complainant alleges:
17	<u>PARTIES</u>
18	1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her
19	official capacity as the Interim Executive Officer of the Board of Registered Nursing, Departmen
20	of Consumer Affairs.
21	2. On or about March 14, 2005, the Board of Registered Nursing (Board) issued
22	Registered Nurse License Number 654439 to Kimberly Lynn Walker (Respondent). The
23	Registered Nurse License was in full force and effect at all times relevant to the charges brought
24	herein and will expire on December 31, 2010, unless renewed.
25	JURISDICTION
26	3. This Accusation is brought before the Board under the authority of the following
27	laws. All section references are to the Business and Professions Code unless otherwise indicated.
00	

STATUTORY PROVISIONS

- 4. Section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.
- 5. Section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.
 - 6. Section 2761 states, in pertinent part:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

- "(a) Unprofessional conduct, which includes, but is not limited to, the following:
- "(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."
 - 7. Section 2762 states, in pertinent part:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

- "(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.
- "(b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.

28-||-///

///

"(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

REGULATORY PROVISION

8. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

CONTROLLED SUBSTANCES/DANGEROUS DRUGS

- 9. Cefoxtin is an antibiotic and is a dangerous drug as defined in section 4022.
- 10. Demerol (brand name for Meperidine Hydrochloride) is a Schedule II controlled substance as designated by Health and Safety Code section 11055, and is a dangerous drug as defined in section 4022.
- 11. Fentanyl (an opiate) is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivisions (a) and (c)(8), and is a dangerous drug as defined in section 4022.
- 12. Lorazepam or Ativan (a benzodiazepine) is a Schedule IV controlled substance as defined in Health and Safety Code section 11057, subdivisions (a) and (d)(16), and is a dangerous drug as defined in section 4022.
- 13. Morphine Sulfate (an opiate) is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivisions (a) and (b)(1), and is a dangerous drug as defined in section 4022.

14. Section 4022 states, in pertinent part:

"Dangerous drug' or 'dangerous device' means any drug or device unsafe for self-use in humans or animals, and includes the following:

- "(a) Any drug that bears the legend: 'Caution: federal law prohibits dispensing without a prescription,' 'Rx only,' or words of similar import.
- "(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006."

COST RECOVERY PROVISION

15. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

STATEMENT OF FACTS

Incident at St. John's Pleasant Hospital

- 16. On or about May 28, 2008, while working as a nurse at St. John's Pleasant Valley Hospital in Camarillo, California, Respondent went missing from her unit for approximately one hour. When she returned to the unit, Respondent reported that she had a medical issue. Hospital staff escorted Respondent to the emergency room. According to the staff, Respondent appeared to be impaired and in need of medical attention. In the emergency room, Respondent submitted to tests, including a drug screen. Respondent tested positive for opiates and benzodiazepines.
- dispensing system, and compared it to the medication administration records (MARs) for Respondent's assigned patients. This review revealed that, for several of the doses of narcotic medications that Respondent withdrew from the Pyxis system, there was no record of these medications having been administered to patients. The medications which were unaccounted for included 18 mg of Morphine Sulfate, 6 mg of Lorazepam, three tablets of Morphine Sulfate SR 30 mg, and one 100 mcg Fentanyl patch.

///

-///

Incident at Good Samaritan Hospital

- 18. On or about October 28, 2007, while Respondent was working as a nurse at Good Samaritan Hospital in Los Angeles, California, hospital staff noticed the frequency with which Respondent went to the Omnicell drug dispensing station.
- 19. An activity report from the hospital's Omnicell system indicated that Respondent withdrew four doses of Demerol 75 mg for her assigned patient. The medication administration record (MAR) for that patient indicated that Respondent administered two doses of Demerol. The patient confirmed that she received Demerol twice during Respondent's shift. The other two doses of Demerol 75 mg that Respondent withdrew, 150 mg total, were unaccounted for. Incident at Verdugo Hills Hospital
- 20. On or about April 19, 2007, while working as a nurse at Verdugo Hills Hospital in Glendale, California, Respondent documented that she signed out and administered three doses of Demerol 75 mg to a patient (Patient A). There was no physician order for Demerol for Patient A and Patient A denied receiving the medication. Hospital staff also determined that Respondent failed to administer a dose of Cefoxtin antibiotic IVPB that was ordered by a physician for Patient A.
- 21. On the same day, Respondent signed out six doses of Demerol 75 mg for another patient (Patient B). A physician had ordered three doses of Demerol for Patient B. However, Patient B denied receiving any doses of Demerol during Respondent's shift.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

22. Respondent is subject to disciplinary action under section 2761, subdivision (a)(1), on the grounds of gross negligence as defined in California Code of Regulations, title 16, section 1442, in that Respondent withdrew controlled substances/dangerous drugs, but failed to administer the drugs to patients or waste the drugs. Complainant refers to and incorporates all of the allegations in paragraphs 16 through 21, inclusive, as though set forth fully.

à

SECOND CAUSE FOR DISCIPLINE

(Illegally Obtained or Possessed Controlled Substances/Dangerous Drugs)

23. Respondent is subject to disciplinary action under section 2762, subdivision (a), on the grounds of unprofessional conduct, in that Respondent obtained or possessed in violation of law controlled substances/dangerous drugs. On or about May 28, 2008, October 28, 2007 and April 19, 2007, Respondent withdrew controlled substances/dangerous drugs, but failed to administer the drugs to patients or waste the drugs. Complainant refers to and incorporates all of the allegations in paragraphs 16 through 21, inclusive, as though set forth fully.

THIRD CAUSE FOR DISCIPLINE

(Dangerous Use of Controlled Substance)

24. Respondent is subject to disciplinary action under section 2762, subdivision (b), on the grounds of unprofessional conduct, in that Respondent used a controlled substance/dangerous drug to an extent or in a manner dangerous or injurious to herself, any other person, or the public or to the extent that such use impaired her ability to conduct with safety to the public the practice authorized by her license. The circumstances are as follows:

On or about May 28, 2008, while on duty as a nurse, hospital staff noticed that Respondent appeared to be chemically impaired and in need of medical attention. Hospital staff escorted Respondent to the emergency room where Respondent tested positive for opiates and benzodiazepines. Complainant refers to and incorporates all of the allegations in paragraphs 16 through 17, inclusive, as though set forth fully.

FOURTH CAUSE FOR DISCIPLINE

(Falsified or Grossly Incorrect Entry in Hospital Record)

25. Respondent is subject to disciplinary action under section 2762, subdivision (e), on the grounds of unprofessional conduct, in that Respondent falsified or made a grossly incorrect entry in a hospital record pertaining to a controlled substance/dangerous drug. On or about April 19, 2007, Respondent charted that she administered various controlled substances/dangerous drugs to patients when, in fact, she did not administer those controlled substances/dangerous

28--||-///

drugs. Complainant refers to and incorporates all of the allegations in paragraphs 20 through 21,
inclusive, as though set forth fully.
<u>PRAYER</u>
WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,
and that following the hearing, the Board issue a decision:
1. Revoking or suspending Registered Nurse License Number 654439, issued to
Kimberly Lynn Walker;
2. Ordering Kimberly Lynn Walker to pay the Board the reasonable costs of the
investigation and enforcement of this case, pursuant to Business and Professions Code section
125.3; and
3. Taking such other and further action as deemed necessary and proper.
DATED: 3/8/10 Mare term LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer Board of Registered Nursing
Department of Consumer Affairs State of California
Complainant
LA2009603962
50579053.doc
•